

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034467

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2285

STATE FILE NUMBER

FILED AUG 23 1963

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch</b>		Length of stay in lb <b>34 days</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>McKinley Hotel</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Kinkelo</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-13-13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shearman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Metal Mfg.</b>	
11a. BIRTHPLACE (City and state or country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Frank Kinkelo</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Rody</b>	
14. NAME OF HUSBAND OR WIFE <b>Margaret Craft Kinkelo</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>yes</b>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis w. cavitation for advanced.</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cachexia</b> DUE TO (c) <b>002.7</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>10</b> a.m. <b>p.</b> Month, Day, Year <b>7-12-63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	
20g. COUNTY <b>Mo.</b>		20h. STATE <b>Mo.</b>	
21. I attended the deceased from <b>6-9-63</b> to <b>7-12-63</b> and last saw <input checked="" type="checkbox"/> him alive on <b>7-12-63</b> Death occurred at <b>10</b> p. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Bernard J. Cullen</b> M.D.		22b. ADDRESS <b>Robt. Koch Hosp. - Koch, Mo.</b>	
22c. DATE SIGNED <b>7-15-63</b>		22d. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
22e. LOCATION (City, town, or county) <b>St. Louis</b>		22f. STATE <b>Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/18/63</b>	
23c. NAME OF FUNERAL DIRECTOR <b>Cullen &amp; Kelly</b>		23d. ADDRESS <b>7267 Natural Bridge</b>	
23e. DATE RECD. BY LOCAL REG. <b>7-18-63</b>		23f. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

1 4000

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41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me;

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James C. Lammers*

Licensed Embalmer No. 4142

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.